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Hong Kong Physiotherapy Journal (2011) 29, 64–70

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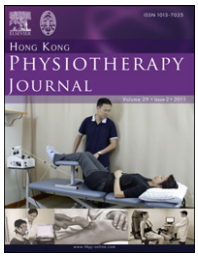

RESEARCH REPORT

The slave of duty: Why clinical educators across the continuum of care provide clinical education in physiotherapy

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KEYWORDS
clinical education;
clinical educators;
perceptions;
physiotherapy students;
placements

Abstract This study was a qualitative investigation aimed at exploring clinical educator's perceptions of the clinical education experience and barriers to providing more clinical education. An online questionnaire was sent to physiotherapy clinical educators at hospital and community sites operated by Southern Health in Victoria, Australia. Using the responses, a framework involving key themes "motivators for delivering clinical education," "consequences of delivering clinical education," and "beneficiaries of clinical education" was constructed. Motivation for delivering clinical education was consistently reported as duty or responsibility. Consequences of delivering clinical education were comprised of positive effects on department profile, educator professional development, student professional development, and development of the physiotherapy profession, and negative effects on non-clinical tasks. The effect of clinical education on workload was seen as both positive and negative, depending on student ability, attitude, and quantity, as well as on staffing levels. These consequences were distributed across a range of beneficiaries of clinical education, inclusive of students, educators, patients, the department, and the profession. Strategies aimed at enhancing the positive aspects and managing the negative aspects for the clinical educator may be more successful in increasing capacity for student placements.
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Introduction

Education in the clinical setting is a core component of the undergraduate curriculum in most health professions. Immersion in clinical practice offers a distinct experience that cannot be simulated effectively in any other setting. In

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doi:10.1016/j.hkpj.2011.06.002

Australia, we are currently, and will "continue to experience increased demand for health care workers at a rate that will challenge training and service delivery systems" [1]. The escalating demand for health care professionals is being felt world-wide, and the ability to meet this demand is significantly influenced by the capacity of the clinical training systems.

There are a number of factors that may impact on the capacity of existing health services to offer clinical education placements. Central among these is the contribution of "clinical educator" health professionals, who provide education in the clinical context to student health professionals. For the most part, capacity relies on the "good will" of these clinical educators [2] and their motivation to provide clinical education placements. Several investigations [3—6] have examined clinical educator perceptions of their role and have consistently identified that the role of the clinical educator is perceived as complex, stressful, and time intensive. Calls for greater professional development and support for clinicians in their roles as educators have been made consequent to this. However, these investigations have not directly considered how clinical educator perceptions could be harnessed to build clinical education quality and capacity.

Enhancing clinical education quality and capacity has also been investigated through conduct of trials comparing various approaches to clinical education [7—16]. These investigations have found that alternative clinical education models (such as the 1:2 educator:student ratio) may offer some additional benefit to capacity, productivity, and the students learning experience. Advantages and disadvantages for the clinical educator have been identified, but investigators have not asked educators to prioritise or weight these factors, or preference a particular model, and that still, the "1:1 model remains very popular with the educators" [8]. This highlights that although research evidence may suggest that alternative approaches may be successful, the perceptions of clinical educators have not been sufficiently explored and harnessed to ensure that these approaches are translated into clinical practice.

It has been recognised that certain models may not be appropriate in all health care settings [8]. There is also evidence to suggest that the effectiveness of clinical education is complicated by contextual factors [17], which may differ in various settings; however, this potential difference across the continuum of care has not been explored further.

More research is needed to understand factors that may promote capacity and best practice in clinical education, so that a work force that is sufficient in number and quality to cope with current and future demands can be established in a sustainable manner. If we can understand clinicians' perceptions of clinical education to a greater degree, we can devise strategies to complement the advantages and provide support mechanisms for the disadvantages, and use these strategies to ensure that alternative models of clinical education that are supported by evidence are embraced by clinical educators and translated into practice.

This study aimed to understand how clinical educators perceive clinical education as a component of their practice and what advantages and disadvantages they feel they incur as a result of participating in clinical education. We also aim to understand barriers clinical educators perceive they face in offering greater quality and quantity of clinical education and whether these perceptions differed across the continuum of care. Answering these questions will provide insights into how various interventions may be accepted and implemented by clinical educators and allow generation of hypotheses as yet untested.

Method

Design

This study was a cross-sectional, qualitative survey.

Participants and setting

Physiotherapists providing clinical education to graduate entry physiotherapy students within Southern Health, Victoria, Australia, were targeted as participants for this study. Southern Health comprises six distinct hospital campuses in addition to community health and rehabilitation centres. Across Southern Health, approximately 70 students undertaking 2500 placement days are educated annually.

Measurement instruments

The survey was e-mail based, comprising five open-ended questions, which was distributed to clinical educators as part of a wider questionnaire.

The questions included were as follows:

- Is clinical education a core role of professional physiotherapists?
- What are the advantages of clinical placements and students in the workplace?
- What are the disadvantages of clinical placements and students in the workplace?
- What are the barriers to offering more student placements in your area?
- If any, what were the limitations to providing clinical education to a standard that met your expectations?

Procedure

Information regarding this project was provided to clinical education coordinators at each of the six Southern Health hospital campuses, a community health clinical education coordinator, and a community rehabilitation clinical education coordinator throughout 2008 during monthly face-to-face meetings with the project principal investigator. An explanatory statement for this project and an electronic link to the online survey was e-mailed to these clinical education coordinators in October 2008. Clinical education coordinators were asked to forward this link to staff members who had been involved in the clinical education of physiotherapy students during 2008. Clinical educators were then able to complete the survey over the following month. This was a health service quality initiative, and approval for this study was provided by the

Southern Health Human Research Ethics Committee. Survey completion was deemed as providing implied consent from project participants. Implied consent for survey-based research where there is minimal risk of harm to participants is an acceptable form of consent under the National Health and Medical Research Council guidelines for ethical conduct of research in Australia [18].

Analysis

Analyses were undertaken using a framework approach [19]. Five stages of analysis were undertaken by two members of the investigative team (S.S. and T.H.). These stages were (1) familiarisation with the data; (2) identifying the key issues, concepts, and themes; (3) systematically indexing the data; (4) charting the data according to the thematic framework; and (5) mapping and interpreting the data, finding associations between themes with the aim to provide explanations for the findings.

The investigators who conducted these analyses performed the first four stages independently of each other. They then met and compared their results with this stage of the analysis, resolving differences in interpretation and charting of data through negotiation. The fifth stage was then undertaken in collaboration.

Results

Responses were received from 28 out of a possible 50 clinical educators (response rate, 56%). There were 20 respondents from the hospital setting and eight from a community setting. There were six Grade 3 (senior) physiotherapists, 19 Grade 2 (intermediate) physiotherapists, and three Grade 1 (junior) physiotherapists among the respondents.

One hundred forty-two comments were identified from the responses to the five questions. Twenty-one issues within comments were identified and labelled. The responses to the survey items were then grouped to establish a broader framework for understanding how capacity for providing clinical education could be enhanced. Three overarching themes arose: "motivators for delivering clinical education," "consequences of delivering clinical education," and "beneficiaries of clinical education" (Fig. 1). These themes address the questions of "why do they do it?"; "what happens when they do it?"; and "whom does this affect?" respectively.

Most (89%) of the respondents said that clinical education is a core role of professional physiotherapists. Respondents commented that, as part of their role, they complete the main tasks of student education, non-clinical duties, and their clinical workload. The principal motivation for delivering clinical education was consistently reported as duty or responsibility. This could be self-initiated, for example, "*we have a responsibility to provide students with as much information and training as possible [participant (p).6]*" or externally initiated by job description or setting, for example, "*in a teaching hospital it must be a necessary element [p.15]*" and "*it depends on the job description [p.19],*" whereas one respondent described it as being forced on them "*it is whether you like it or not [p.26].* "

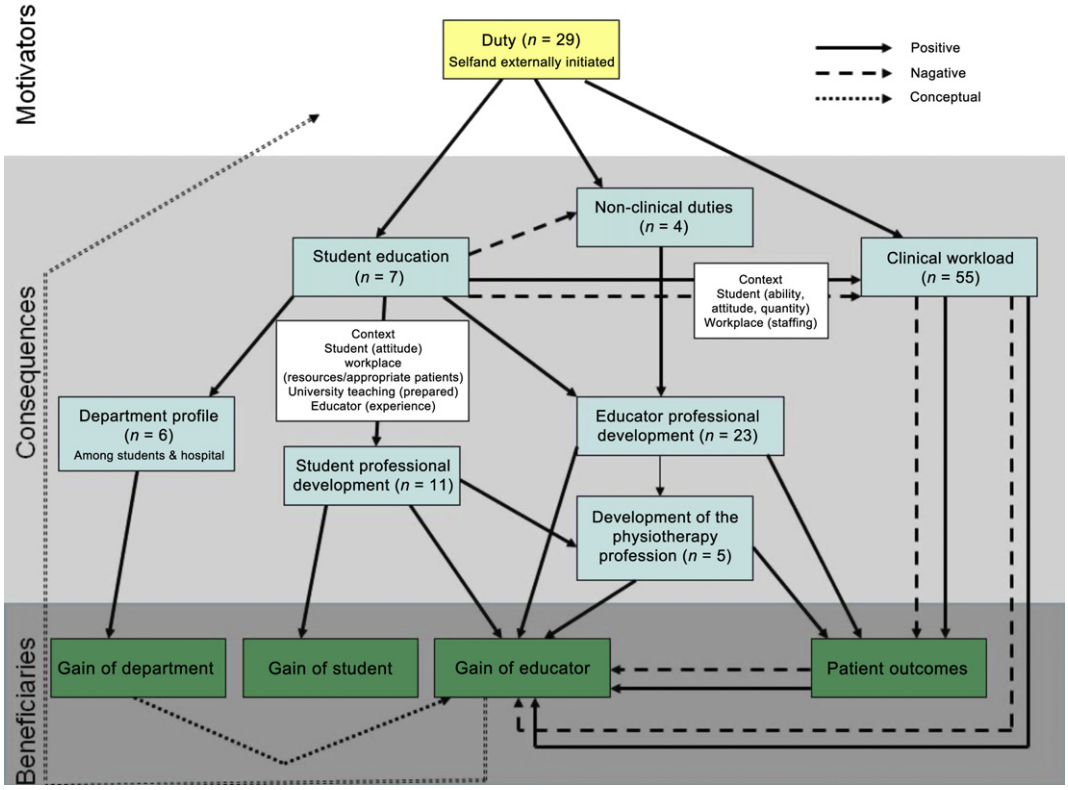

Figure 1. Themes arising from the survey responses. Numbers specified in this figure relate to the number of comments received, not the number of participants who made them.

The consequences of delivering clinical education were both positive and negative, depending on the student ability, attitude, quantity, and preparedness, and the workplace resources and educators' level of experience. The consequences of delivering clinical education were distributed across a range of beneficiaries of clinical education, inclusive of students, educators, patients, the department, and the profession.

Positive consequences of delivering clinical education were comprised of effects on:

1. *Department profile*, by exposing students to different services across the continuum of care, and particularly, by targeting placements in areas with recruitment difficulties;
2. *Educator professional development*: when delivering clinical education, educators are exposed to current trends and evidence by students, and they must "unpack" and verbalise their own clinical reasoning, thus further cementing their own knowledge;
3. *Student professional development*: it is well recognised that clinical placements are vital for student development. The degree of student development was seen to be affected by the ability to source the appropriate number and type of patients and by the level of experience of the clinical educator; and
4. *Development of the physiotherapy profession*: clinical educators felt it was part of their professional responsibility to ensure the competence of the future clinicians in their profession.

Advantages of clinical education and students in the workplace were identified by all respondents. Educator professional development was reported as an advantage by 100% of both hospital- and community-based clinicians. *"A student can challenge your knowledge and help keep you up to date with EBP/skills [p.11]."* Educators referred to students as not only assisting in improving knowledge—*"keeps me up to date [p.25]"*—but also in further developing clinical reasoning—*"sharpens your own clinical decision making skills [p.21]"*—and reflection—*"having students in the workplace facilitates the critical reflection of staff on their own practice [p.2]."* Respondents also valued students' positive effect on their own teaching skills: *"improves staff own skills at education both students and their own patients [p.2]"* and *"learning to be an educator [p.23]."* Respondents recognised the positive effect of students on the profile of their department and the flow-on to improved recruitment *"increases the awareness of rehabilitation and in general the site [p.20]"* and *"potential of future employment [p.16]."*

The disadvantages of clinical education were largely recognised as increased workload because it takes time to supervise students: *"students take a lot of time [p.7]."* Some respondents put this in the context of the students' preparation: *"time demands, especially those who are poorly prepared [p.3]."* The time-consuming nature of students was also reflected in responses that referred to other tasks being deferred during clinical education placements *"lots of jobs and tasks need to go 'on hold' while students are on the ward [p.2]"* and *"other areas of responsibility suffer [p.5]."* Respondents commented that the extra time taken when supervising students negatively affected their non-clinical duties, as these tasks with less of a priority are at the expense of the time taken for student supervision and patient care. Duties, such as quality projects and administration, are also often performed during "non-clinical" time, and a decrease in the ability to carry out such tasks may negatively impact on educators' job satisfaction.

Many respondents commented that this increased demand on time and deferring other responsibilities caused stress and reduced job satisfaction for the clinical educator: *"added stress on the workload of the supervisor, time constraints and the need to continue a full caseload [p.6]"*; *"very intensive for the clinician to have to provide appropriate care for patients as well as support for students [p.19]"*: *"takes time and puts pressure on the remainder of your day, also limits ability to complete administrative and quality tasks [p.12]"*: *"students can be very challenging and draining [p.2]."*

The effect of clinical education on workload was seen as both positive and negative, depending on student ability, attitude, and quantity, with able students assisting with the educator's workload: *"good students can help with the workload [p.25]"* and *"can help with workloads by the end of placements [p.26]."* Competent students were seen as assisting with clinical educators' workload; however, this was more commonly towards the end of the placement. Underperforming students were seen as putting extra pressure on time and workload *"students are very time consuming, particularly those who require a lot of help to reach competent levels [p.5]."* Equally, the student context affects the motivation and job satisfaction of the clinical educator positively and negatively. Students who perform well, have a positive attitude, and are self-motivated were seen as rewarding and improving job satisfaction, whereas underperforming students were identified as particularly stressful and negatively impacting on job satisfaction. The quantity of students was also linked with the consequences of clinical education, with too many students seen not only as a stressor but also as having an impact on the quality of education provided.

Barriers to increasing capacity of clinical placements were very closely linked with the disadvantages of students in the workplace. Some respondents (21%) referred to time as a barrier *"can be very time consuming for staff so that they may not be able to get other work duties done [p.4],"* whereas 46% of the respondents referred to staffing as a barrier: *"limited EFT to cover clinical caseload [p.2]"* and *"not enough physios to supervise more students [p.6]."* A number of respondents referred to lack of patients as a barrier to offering more clinical placements—*"lack of patients to see [p.26],"* *"patient numbers and appropriate patients [p.25]"*—as well as a lack of space and resources available for the students to use.

Limitations to the quality of clinical education provided were also closely linked with the themes previously arising. Many responses related to time pressures and workload impacting on the standard of education provided *"time restraints [p.15]"* and *"the need to juggle students and workload [p.6]."* Two respondents felt that their *"experience as a clinical educator [p.17 and 20]"* limited the quality of the placement.

The effect of clinical education on the patient was seen as both positive and negative, depending on how the clinical educator was being affected. If the student was aiding the educator's workload, then it could positively influence patients' outcomes as they may receive more intervention. Conversely, if the student is hindering the educator's workload, it could negatively influence the patient care if it is not able to be adequately absorbed across other members of the team. If the clinical educator's professional development was enhanced by the delivery of clinical education, then the patient could potentially benefit in the treatment options or education they receive. Ongoing development of the physiotherapy profession through quality clinical education ultimately benefits the quality of patient care provided.

The key differences across the continuum of care were the responses relating to the effect of students on the department profile and responses relating to the ongoing development of the physiotherapy profession. The recognition that students may have a positive effect on the profile of the department was made by a larger proportion of community-based clinical educators (50%) than hospital-based educators (10%). Only hospital-based educators commented on the provision of clinical education having gains for the physiotherapy profession. Responses relating to the other themes were consistent across the continuum of care.

Discussion

Motivators for delivering clinical education

Overwhelmingly, clinical educators identified a strong sense of duty to provide clinical education. This could have been both internally driven by professional responsibility and externally driven by job description or setting. Clinical educators were able to recognise that the provision of clinical education can benefit the department, the student, the educator, and the patient.

A large proportion of responses to all questions focussed on gains and losses for the individual clinical educator. This is not unexpected given the only participants were clinical educators. Nonetheless, models to increase capacity that maximise potential for clinical educator gain may be more readily accepted. Strategies aimed at enhancing the positive aspects identified may be more successful in increasing capacity for student placements.

Consequences of delivering clinical education

Across the continuum, educators highly valued students enhancing their own professional development. To maximise educator gain, placement providers need to work with universities to further develop this advantage. For example, a compulsory student assessment project done on clinic on a topic chosen by the educator presented back to departmental staff or a department quality project run by the student may assist in increasing educator satisfaction.

Non-clinical duties were seemingly pushed aside when students were in the workplace. Universities and placement providers could look at ways to incorporate some of these duties into the normal part of student placement, for example, a student completing a quality task, ensuring students record their own statistics, or students being involved in administrative tasks.

The increase in workload as a result of students was the most commonly reported barrier to increasing the number of clinical education placements that could be offered. Providing clinical education involves juggling demands of educators' normal clinical duties within the time frames dictated by the service. More professional development for clinical educators needs to be targeted around workload management. Often, ideas, such as students spending time observing procedures or other disciplines, attending meetings, writing reflective essays, and others, are not seen as important as spending time with an educator assessing or treating a patient. The "gold standard" in clinical education is still seen as saturating students with patient contact. Anecdotally, however, students report that some of these observational and reflective tasks can add depth to their understanding of principles, such as team work, professionalism, communication, and patient-centred care, which are all important components of a clinical placement. In addition to this, reflection is an essential skill for students to learn, and clinical educators "must assist students to become reflective thinkers so that they will be better prepared …" [20]. Students are often under significant stress while undertaking clinical placements [21,22], and this may be further exacerbated by feeling overwhelmed by the intensity of large numbers of patients. This high cognitive load without time for reflection may mean that some of the intended learning is lost [23]. More work needs to be done around promoting educator-time-saving tasks students could undertake, which are enriching to the clinical education experience and do not affect the quality of the placement.

There was a large degree of overlap between factors influencing capacity and quality, indicating that capacity was limited to a quantity where educators felt they could deliver quality clinical education. This aspect could be specifically targeted in professional development for clinical educators exploring strategies for maintaining quality in clinical education delivery while supervising multiple students.

Any strategies aimed at enhancing the quality and capacity of clinical education should consider the impact of the clinical education process on the clinical educator. Factors likely to influence the capacity of a clinical educator to provide clinical education include the student ability, attitude, quantity, and preparedness; the workplace resources; and educators' level of experience.

Beneficiaries of clinical education

Clinical educators identified that the consequences of delivering clinical education may affect students, educators, patients, the department, and the profession. The perceived benefits of clinical education delivery were interdependent. As the delivery of clinical education can potentially positively or negatively impact the quality of patient care, this can, in turn, directly affect educators'

job satisfaction. The gains to the department can also benefit the educator as an increase in department profile may improve educators' job satisfaction. The gain of the student can be a rewarding experience for the educator (a form of altruism), thus directly improving the educator's job satisfaction. The positive effect of delivering clinical education on educators' job satisfaction has a potential to benefit the department by means of improvement in recruitment and retention of key personnel.

Differences across the continuum of care

Community-based educators commented more often than hospital-based educators on students' increasing department profile and improving recruitment. This could be explained by the fact that there are more staff recruitment and retention difficulties in community areas in Australia [1]. This aspect could be enhanced by exploring more ways students can be exposed to community areas, such as shared placements and community electives, and specifically highlighting the outcome of these to clinical educators. For example, feedback could be given to community-based clinical educators on the number of past students who have been employed or gather feedback on the number of past students who would now consider working in a community setting. Only hospital-based educators commented on gains for the physiotherapy profession. One possible explanation for this is that a large number of department-based clinicians may identify more with their professional discipline compared with community-based clinicians who work closely within multidisciplinary teams. This highlights that the potential benefits of clinical education for the physiotherapy profession would not be a motivating factor for department-based clinicians.

The results of this study support conclusions from other research. The outcome of most of the clinical educators reporting that clinical education is a core role of professional physiotherapists resonates with the work of Baldry-Currens and Bithell in 2000 [24]. A clear articulation of the sense of duty as the predominant motivator for providing clinical education has not been presented in other studies. The positive effect of providing clinical education on educator professional development has been identified previously [6], along with the increased workload of students being the greatest barrier to increasing capacity [5,6,17]. The call for greater support, education, and training for clinical educators is one that continues to be raised [4—6,24], and clearly, the need for this is still not being met. Differences between the perceptions of community- and hospital-based clinical educators have not previously been examined.

Limitations

Wider issues may have been missed in this study owing to the moderate response rate. There may be key issues relating specifically to clinicians who did not respond. For example, clinicians who have a particularly negative view of clinical education may have chosen not to respond to the survey or not to be involved in the clinical education program in 2008.

The survey questions used were not phrased to target evidence-based themes, and full development of the theoretical framework occurred after receipt of the data rather than in advance. This research was conducted in one clinical school within one health care network dealing with one university, which may limit its generalisability.

Future Research

The area of greatest concern arising from this investigation was the effect of clinical education on staff workloads. Further research is clearly needed to identify models of clinical education provision that mitigate the effect of additional clinical education workloads on clinical educators. At present, it is unknown how the additional work created by providing clinical education is incorporated into the daily workload of the clinical educators. It is highly likely that some tasks would be distributed to other staff members, whereas other tasks will be delayed until workloads return to previous levels. However, even if clinical education models can be identified that minimise workload burden on clinical educators, there is no guarantee that implementation of such models will enhance the willingness of clinical educators to provide placements for a greater number of students. Therefore, future research should concurrently consider the effects of clinical education models on both willingness to accept additional students and workloads in addition to other relevant outcomes.

Conclusion

This study was designed to examine the perceptions of clinical educators, why they offer clinical education placements, and whether these opinions differed across the continuum of care. Understanding clinical educators' motivations and views is essential to ensure that proposed solutions are effectively translated into everyday clinical practice.

This study provides insights into the motivation of clinical educators to perform clinical education and presents suggestions on how to use the perceived advantages and offset the perceived disadvantages of offering clinical education placements to maximise quality and capacity. Areas of difference across the continuum of care have been highlighted with potential explanations offered.

Suggestions presented in this study may be useful to education providers, health services, and clinical educators looking to improve the satisfaction of clinical educators and/or the quality of and capacity for clinical education placements.

Acknowledgements

The authors gratefully acknowledge the contributions of the physiotherapy clinical educators who contributed to this survey. The authors declare that there are no conflicts of interest or financial interests related to the material in this manuscript.

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